CHAPTER 75

PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY SERVICES FOR INDIVIDUALS UNDER AGE 21

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SUBCHAPTER 1. GENERAL PROVISIONS

10:75-1.1 Purpose and scope

(a) This chapter outlines the policies and procedures relevant to the provision of psychiatric residential treatment facility services to individuals under age 21 enrolled in Medicaid/NJ FamilyCare-Plan A. The rules of this chapter also apply to children/youth/young adults enrolled in the Partnership for Children (PFC), whether or not they are eligible for Medicaid/NJ FamilyCare.

(b) Unless otherwise stated herein, the rules of this chapter apply to psychiatric residential treatment facility (PRTF) services rendered to Medicaid and NJ FamilyCare beneficiaries under the Medicaid/NJ FamilyCare fee-for- service program. PRTF services which are provided by the beneficiary's selected managed care organization (MCO) are governed and administered by that MCO.

10:75-1.2 Definitions

The following words and terms, when used in this chapter, shall have the following meanings, unless the context clearly indicates otherwise:

"Active treatment" means the implementation of a professionally developed and supervised plan of care that is developed and implemented no later than 14 days after admission and designed to achieve the goal of the resident's appropriate discharge from the PRTF at the earliest possible date. (See 42 C.F.R. 441.154.)

"Beneficiary or eligible beneficiary" means any person who is a qualified applicant receiving benefits under the Medical Assistance and Health Services Act, N.J.S.A. 30:4D-1 et seq.

"Care Management Organization (CMO)" means the community-based Department of Human Services' contracted entity that is responsible for creating, coordinating and implementing a system-wide plan of care for children with emotional and behavioral disturbances that are in need of intensive care coordination services.

"Centers for Medicare and Medicaid Services (CMS)" means the agency of the Federal Department of Health and Human Services which is responsible for the administration of the Medicaid program.

"Certification of need" means an evaluation made by an interdisciplinary medical review team to determine the level of care required to treat a resident with mental illness in the most effective manner in the least restrictive environment.

"Certified nurse practitioner/clinical nurse specialists (CNP/CNS)" means a person currently licensed as an advance practice nurse who is currently certified by the New Jersey State Board of Nursing in accordance with N.J.A.C. 13:37-7 and with N.J.S.A. 45:11-49a through d,

or licensed through a comparable agency of the state in which he or she practices.

"Contract pricing" means the facility-specific rate, based on the rate determined in the contract negotiated with the Division of Mental Health Services, the Division of Youth and Family Services or the Division of Medical Assistance and Health Services.

"Contracted System Administrator (CSA)" means the entity contracted by the Department of Human Services to track all mental health services provided to individuals as part of the PFC, to monitor the quality of care, to prior authorize mental health services and approve continued lengths of stay in hospitals.

"Department (DHS)" means the New Jersey Department of Human Services.

"Division of Medical Assistance and Health Services (DMAHS)" means the organizational component of the New Jersey Department of Human Services which is responsible for the administration of the State's medical assistance programs.

"Division of Mental Health Services (DMHS)" means the organizational component of the New Jersey Department of Human Services which is responsible for the administration of the State's mental health programs.

"Division of Youth and Family Services (DYFS)" means the organizational component of the New Jersey Department of Human Services which administers the Title IV-E program of the Social Security Act, 42 U.S.C. § § 670 through 679b.

"Healthcare Common Procedure Coding System" means a nationwide three-level coding system. Level 1 codes are adapted from codes published by the American Medical Association in the Common Procedure Terminology (CPT) and are utilized primarily by physicians and independent clinical laboratories. Level 2 codes are assigned by CMS for physician and non-physician services that are not in the CPT. Level 3 codes are assigned by DMAHS and are used for services not identified by the CPT or CMS assigned codes.

"Hospital leave" means an absence from the facility for more than 24 consecutive hours due to the resident receiving inpatient treatment in a hospital, including treatment in a psychiatric unit of a hospital.

"Individual plan of care" means a written plan developed for each resident to improve his condition to the extent that inpatient care is no longer indicated.

"Interdisciplinary team," as described in Federal regulations in 42 C.F.R. 441.156, is comprised of those employed by, or those who provide services to Medicaid/NJ FamilyCare or PFC beneficiaries in the PRTF, and is responsible for the review of the treatment needs of a resident receiving mental health services to ensure that the most appropriate level of care is provided. The team shall include, at a minimum, the professional staff listed at N.J.A.C. 10:75-

2.2(b).

"Joint Commission on Accreditation of Healthcare Organizations (JCAHO)" means the nationwide, independent, not-for-profit organization that evaluates and accredits health care organizations and programs, including, but not limited to, behavioral health care organizations including, but not limited to, psychiatric residential treatment facilities.

"New Jersey Medicaid Management Information System (NJMMIS)" means the claims processing entity contracted by DMAHS to process claims for Medicaid/NJ FamilyCare and other health programs that are administered in whole or in part by the Division.

"Partnership for Children (PFC)" means the Department of Human Services' initiative developed to provide a comprehensive approach to the treatment of behavioral and mental disturbances in children, adolescents and young adults. PFC beneficiaries are those individuals under the age of 21 that have been determined by the Department of Human Services to be eligible for enrollment into the PFC, independent of their eligibility for Medicaid/NJ FamilyCare coverage.

"Physician" means a doctor of medicine (M.D.) or osteopathy (D.O.) licensed to practice medicine and surgery by the New Jersey State Board of Medical Examiners, or similarly licensed by comparable agencies of the State in which he or she practices.

"Psychiatric residential treatment facility (PRTF)" means a facility that is not licensed as a hospital, but which meets the requirements in 42 C.F.R. part 441 subpart D, 42 C.F.R. 483 subpart G, and has a provider agreement with the State Medicaid agency (the Division of Medical Assistance and Health Services).

"Resident" means a beneficiary who has been admitted to a PRTF on the recommendation of a physician and who receives services in the PRTF for a 24- hour period or longer in accordance with this chapter.

"Restraint" means a personal hold of any duration, a mechanical restraint, or a drug used as a restraint.

"Serious injury" means any significant impairment of the physical condition of the resident as determined by qualified medical personnel, including, but not limited to, burns, lacerations, bone fractures, substantial hematoma(s), and injuries to internal organs. (See 42 C.F.R. 483.352.)

"Serious occurrence" means the death, suicide attempt or serious injury of a resident. (See 42 C.F.R. 483.374(b).)

"Therapeutic leave" means an absence from the facility, greater than 24 consecutive hours, deemed therapeutic, approved by the treatment team and included in the resident's plan of

care. Reasons for such absence include, but are not limited to, visits with parents or other caregivers, attendance at a residential camp or residence in a temporary shelter.

"Utilization control" means an approved program instituted, implemented and operated by or under the authorization of a utilization review organization (URO) which effectively safeguards against unnecessary or inappropriate Medicaid services and assesses the quality of those services to Medicaid and NJ FamilyCare fee-for-service beneficiaries.

10:75-1.3 Program participation criteria

(a) A psychiatric residential treatment facility (PRTF) that is not licensed as a hospital, but meets the requirements in 42 C.F.R. part 441 subpart D and 42 C.F.R. part 483 subpart G, shall be eligible for participation as a PRTF in the New Jersey Medicaid/NJ FamilyCare program.

(b) All PRTF providers shall be enrolled in the New Jersey Medicaid/NJ FamilyCare program as a residential treatment center providing services to children under the age of 21. This includes the filing of a Medicaid/NJ FamilyCare Provider Application (FD-20), the signing of a Provider Agreement MCNH-38, and submittal of the CMS-1513, Ownership and Control Interest Disclosure. Provider applications and required forms can be obtained from and should be submitted to:

Division of Medical Assistance and Health Services
Office of Provider Enrollment, Mail Code #9
PO Box 712
Trenton, New Jersey 08625-0712

(c) A PRTF located in New Jersey that provides services for New Jersey Medicaid/NJ FamilyCare or PFC beneficiaries under the age of 21 shall, in order to participate in the Medicaid/NJ FamilyCare program:

1. Be licensed by the New Jersey Division of Youth and Family Services as a residential child care facility in accordance with N.J.A.C. 10:127 or by the Division of Mental Health Services as a psychiatric community residence for youth in accordance with N.J.A.C. 10:37B or by the New Jersey Department of Health and Senior Services or other State agencies with the authority to license such facilities to provide care to children;
2. Be accredited as a PRTF by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO); and
3. Provide a copy of their license and a copy of their JCAHO Accreditation to DMAHS, at the address in (b) above, as a condition of enrollment as a Medicaid/NJ FamilyCare provider.

(d) A PRTF located out of New Jersey that provides services for New Jersey Medicaid, NJ FamilyCare or NJ PFC beneficiaries under the age of 21 shall, in order to participate in the New Jersey Medicaid/NJ FamilyCare program:

1. Be licensed as a health care provider by the appropriate State agency (NJ DYFS), or be enrolled as a provider of inpatient psychiatric services for children in the Medicaid program in the State in which they are located;

2. Be accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) as a provider of inpatient psychiatric services for children; and

3. Provide a copy of their license, or their Medicaid enrollment agreement, and a copy of their JCAHO Accreditation to the New Jersey DMAHS, at the address in (b) above, as a condition of enrollment as a Medicaid/NJ FamilyCare provider.

(e) As a condition of enrollment, all PRTF providers shall complete an Attestation of Compliance, indicating that all requirements related to the use of emergency safety interventions in PRTFs as described in 42 C.F.R 483, Subpart G, are met. The form will be included in the enrollment package provided by the Division. If additional copies of this form are needed, they can be obtained from the Office of Provider Enrollment by writing the Division at the address in (b) above.

1. Out-of-State providers who are enrolled in the New Jersey Medicaid/NJ FamilyCare program as a PRTF and are not enrolled within their own state Medicaid agency shall file their attestation with the NJ DMAHS at the address in (b) above.

2. Out-of-State providers who are enrolled in the New Jersey Medicaid/NJ FamilyCare program as a PRTF and are also enrolled as a PRTF with their own state Medicaid agency shall file a copy of their state agency's attestation form with the NJ DMAHS at the address in (b) above.

(f) Upon approval as a Medicaid/NJ FamilyCare provider, providers shall comply with the provisions of N.J.A.C. 10:49, in addition to this chapter.

(g) All providers, in-State or out-of-State, shall notify the DMAHS Office of Provider Enrollment (Provider Enrollment) at the address in (b) above, if their license or JCAHO accreditation is terminated, suspended or not renewed, within five business days of the action taken against their license or accreditation.

1. The provider will be disenrolled as a Medicaid/NJ FamilyCare provider until such time as the license or accreditation is restored.

2. Once the provider's license and/or accreditation is restored by the appropriate agency, the provider shall notify Provider Enrollment, who will reinstate the provider as a Medicaid/NJ FamilyCare provider as long as the requirements of N.J.A.C. 10:49 and this chapter are met and continue to be met. The notification to Provider Enrollment shall be in writing and shall include documentation from the licensing or accreditation agency that the provider's license or accreditation has been restored, as well as the specific facts and circumstances regarding the action against the license or accreditation, and the restoration.

3. A PRTF provider shall be held liable for recoupment of any monies paid for services during the time that the provider did not possess a valid license and accreditation.

10:75-1.4 Beneficiary eligibility

(a) Medicaid/NJ FamilyCare beneficiaries under age 21, and those non- Medicaid/NJ FamilyCare-eligible children who are enrolled in the Partnership for Children (PFC) who require PRTF services, shall be eligible to receive services in a psychiatric residential treatment facility (PRTF).

(b) A Medicaid/NJ FamilyCare or PFC resident who was receiving services immediately prior to attaining age 21 may continue to receive services until they are no longer needed or until the resident reaches age 22, whichever occurs first.

10:75-1.5 Recordkeeping

(a) PRTFs shall keep such legible individual records for each resident as are necessary to fully disclose the kind and extent of services provided, as well as the medical necessity for those services. This information shall be available upon the request of the DHS or its authorized agents, including, but not limited to, DMAHS, the Care Management Organization (CMO) and/or the Contracted Systems Administrator (CSA), as well as the Department of Health and Senior Services (DHSS) and the Centers for Medicare and Medicaid Services (CMS).

(b) An individual record shall be maintained for each Medicaid/NJ FamilyCare/NJ FamilyCare/PFC resident. The record shall include the individual's medical, nursing, social and related treatment and care in accordance with this chapter and all accepted professional standards.

(c) All clinical records of discharged residents shall be completed promptly and shall be filed and retained for a period of five years after the discharge of the resident.

(d) If the resident is transferred to or from another PRTF or program, a copy of the resident clinical record, or a summary of the record, shall accompany the resident.

(e) All information contained in the clinical records shall be treated as confidential and shall be disclosed only to authorized persons, including the Department and its agents, the CSA and the CMO.

10:75-1.6 Serious occurrences

(a) A serious occurrence is defined as the death, suicide attempt or serious injury of a resident. A serious injury is defined as any significant impairment of the physical condition of the resident as determined by qualified medical personnel, including, but not limited to, burns, lacerations, bone fractures, substantial hematoma(s) and injuries to internal organs, whether self-inflicted or inflicted by someone else. In the event of any serious occurrence, all PRTF providers shall report the occurrence to the appropriate authorities in accordance with 42 C.F.R. 483.374(b) and (b) through (d) below.

(b) All reports of serious occurrences shall include, at a minimum, the following information:

1. The name of the resident;
2. A detailed description of the occurrence;
3. The name, street address and telephone number of the facility; and
4. Any other information the PRTF is able to provide regarding the occurrence.

(c) In-State PRTF providers who are licensed by, and under contract with, the Division of Youth and Family Services (DYFS) or the Division of Mental Health Services (DMHS) shall report all serious occurrences as follows:

1. All serious occurrences shall be reported to the provider's respective licensing and contracting agency in accordance with agreed upon reporting procedures between the provider and the agency.

2. All serious occurrences shall be reported to the New Jersey Protection and Advocacy Agency no later than the next business day after the incident. Reports shall be mailed to:

NJ Protection and Advocacy
210 South Broad Street, 3rd Floor
Trenton, NJ 08608

3. If the resident is a minor (under age 18), the parents or legal guardians shall be notified as soon as reasonably possible, but no later than 24 hours after the incident.

4. If the resident dies as a result of the serious occurrence, the incident shall additionally be reported to the Centers for Medicare & Medicaid Services as soon as reasonably possible, but the report should be mailed no later than the next business day after the incident. Reports shall be mailed to:

Regional Administrator
Division of Medicaid and State Operations
Centers for Medicare & Medicaid Services
Room 3800
26 Federal Plaza
New York, NY 10278

(d) In-State PRTF providers who are licensed by, and under contract with, agencies other than DYFS or DMHS shall report all serious occurrences as follows:

1. All serious occurrences must be reported to DMAHS via phone call and by completing and filing (Fax and hard copy) an "Initial Serious Occurrence Incident Report Form" (FD-400).

i. The report must be filed by telephone and Fax as soon as reasonably possible, but no later than 24 hours after the incident.

ii. The report must be mailed no later than the close of business on the next regular business day. Providers shall mail the report to:

DMAHS Incident Report Coordinator
PO Box 712
Mail Code #18
Trenton, NJ 08625-0712

2. All serious occurrences shall be reported to the New Jersey Protection and Advocacy Agency no later than the next business day after the incident. Reports shall be mailed to:

NJ Protection and Advocacy
210 South Broad Street, 3rd Floor
Trenton, NJ 08608

3. If the resident is a minor (under age 18), the parents or legal guardians shall be notified as soon as reasonably possible, but no later than 24 hours after the incident.

4. If the resident dies as a result of the serious occurrence, the incident shall additionally be reported to the Centers for Medicare & Medicaid Services as soon as reasonably possible, but the report should be mailed no later than the next business day after the incident. Reports shall be mailed to the CMS Regional Office at the address in (c)4 above.

(e) Out-of-State PRTF providers licensed by, and under contract with, NJ DYFS or DMHS shall report all serious occurrences as follows:

1. In addition to any other procedures required by the State in which the provider is located, all serious occurrences shall be reported to the New Jersey agency that licenses and contracts with the provider, in accordance with the agreed-upon reporting procedures between the provider and the agency;
2. All serious occurrences shall be reported to the designated Protection and Advocacy agency in the State in which the provider is located;
3. If the resident is a minor (under age 18), the parents or legal guardians shall be notified as soon as reasonably possible, but no later than 24 hours after the incident; and
4. If the resident dies, the provider shall also notify the Centers for Medicare & Medicaid Services Regional Office serving the state in which the provider is located. The incident shall be reported as soon as reasonably possible, but the report should be mailed no later than the next business day after the incident.

(f) Out-of-State PRTF providers who are not licensed by and under contract with NJ DYFS or DMHS shall report all serious occurrences as follows:

1. All serious occurrences must be reported to DMAHS via phone call and by completing and filing (Fax and hard copy) an "Initial Serious Occurrences Incident Report Form" (FD-400).
   i. The report must be made by telephone and Fax as soon as reasonably possible, but no later than 24 hours after the incident, to the DMAHS Incident Report Coordinator at the phone and Fax numbers in (c) above.
   ii. The report must be mailed no later than the close of business on the next regular business day. Providers shall mail the report to the DMAHS Incident Report Coordinator at the address in (d)1 above.
2. All serious occurrences must be reported to the designated Protection and Advocacy agency in the state in which the provider is located.
3. If the resident is a minor (under age 18), the parents or legal guardians shall be notified as soon as reasonably possible, but no later than 24 hours after the incident.
4. If the resident dies, the provider shall also notify the Centers for Medicare & Medicaid Services Regional Office serving the state in which the provider is located. The incident shall be reported as soon as reasonably possible, but the report shall be mailed no later than the next business day after the incident.

(g) All PRTF providers, both in-State and out-of-State, who are licensed by and under contract with NJ agencies other than DYFS or DMHS, shall conduct an internal review of the serious occurrence. The provider shall submit a written follow-up report to the DMAHS Incident Report Coordinator at the address in (d)1 above. This report shall be filed no later than 45 working days following the incident. A complete follow-up report shall include, at a minimum:

1. A description of methods used to gather information during the agency's internal review;
2. A more extensive description of the incident, including the date and any and all additional information obtained during the internal review process;
3. Copies of all reports prepared by outside agencies regarding the incident, such as police reports and emergency room reports;
4. A summary of the review of the incident and actions taken by staff during and immediately after the incident, including, but not limited to, any actions that could have been taken to avoid the incident;
5. A description of any and all actions taken by the agency including, but not limited to: staff education, review and revision of policies and procedures, staff debriefing and quality improvement initiatives; and
6. Pertinent findings/conclusions.

(h) The names of all individuals or entities notified of the serious occurrence shall be documented in the resident's record as soon as possible, but no later than 24 hours after the incident occurs. This documentation shall include, at a minimum, the name(s) and agency affiliation of the person making the report, the name(s) and agency affiliation of the individuals who received the report and the time and date the report was made.
For example: "John Doe, child care worker, notified Jane Smith, of Region II CMS, of the serious occurrence that occurred on 02/01/03 at 9:00 P.M., which involved resident Bill Jones."

(i) All entries into the record shall be legible and the person entering the information shall print and sign their name in ink, including their title and the date that the entry was made.

END OF SUBCHAPTER 1

SUBCHAPTER 2. PROGRAM REQUIREMENTS

10:75-2.1 General requirements

(a) Reimbursable PRTF services under the Medicaid/NJ FamilyCare/ Partnership for Children programs shall be those services determined to be medically necessary, using professionally developed criteria and standards of care, and shall be provided under the direction of a physician in a facility that meets the requirements of N.J.A.C. 10:75-1.3.

(b) PRTF services for Medicaid/NJ FamilyCare/PFC beneficiaries under age 21 shall meet the requirements of 42 C.F.R. 441.151. The services shall be provided:

1. Under the direction of a physician;
2. By a facility which is JCAHO accredited; and
3. Before the beneficiary reaches age 21, or, if the beneficiary was receiving such services immediately before he or she reached age 21, services may be provided until the beneficiary no longer requires the services or the beneficiary reaches age 22, whichever event occurs earlier.

10:75-2.2 Certification of need for PRTF services

(a) Prior to admission to the facility, PRTF services shall be certified in writing to be necessary, in accordance with 42 C.F.R. 441.152. Certification of the need for services shall be made by an interdisciplinary team, composed of Department of Human Services (DHS), Care Management Organization (CMO) or the State's Contracted Systems Administrator (CSA) staff, who have knowledge of the child/youth/young adult's situation, are competent in the diagnosis and treatment of mental illness, preferably in child psychiatry and include a physician.

1. For a beneficiary enrolled in the Medicaid/NJ FamilyCare/PFC program before the admission to the PRTF, the certification of need may be completed up to 45 days before admission. The form must be received by the facility prior to the admission of the child/youth/young adult.
2. For children/youth/young adults receiving services coordinated by the PFC, this certification may be completed by the child's CMO or the CSA, if the teams assembled by the CMO or the CSA meet the requirements of 42 C.F.R. 441.152.

(b) The interdisciplinary team shall certify, in writing, that:

1. Ambulatory care resources available in the community do not meet the treatment needs of the child/youth/young adult;
2. Proper treatment of the child/youth/young adult's psychiatric condition requires services on an inpatient basis under the direction of a physician; and
3. Treatment provided in a PRTF can reasonably be expected to improve the child/youth/young adult's condition, or prevent further regression, so that inpatient services would no longer be needed.

10:75-2.3 Authorization for PRTF services

(a) Authorization shall be required for all PRTF services rendered to children/youth/young adults who are enrolled in the PFC. The agency arranging for the child/youth/young adult's admission to the PRTF shall secure the authorization as indicated in (b) and (c) below, and shall document the authorization in the agency record.

(b) For children/youth/young adults who are enrolled in the PFC, upon registration of an ISP, the CSA will issue an authorization number for the services included in the approved ISP to the CMO. The CMO will provide this number, as needed, to the individual providers to use when seeking reimbursement.

(c) For all other beneficiaries receiving PRTF services, authorization for services will be provided by the Division of Youth and Family Services with the certification of need.

10:75-2.4 Individual plan of care

(a) PRTF services shall include "active treatment" in accordance with 42 C.F.R. 441.154. Active treatment means the implementation of a professionally developed and supervised plan of care that is developed and implemented no later than 14 days after admission and designed to achieve the goal of the resident's appropriate discharge from the PRTF at the earliest possible date.

(b) The individual plan of care shall be based on a diagnostic evaluation that includes the examination of the medical, psychological, social, behavioral, and developmental aspects of the resident's current status and shall reflect the need for PRTF care. The appropriate professional personnel shall perform the evaluations.

1. For children/youth/young adults enrolled in the PFC, the plan of care and the diagnostic evaluations shall be completed as part of their Individual Service Plan (ISP) developed by the CMO and shared with the provider who will render the service. See N.J.A.C. 10:73-3.

(c) The individual plan of care shall be developed by the team members identified at N.J.A.C. 10:75-2.4 and shall be developed in consultation with the resident and the resident's parents, legal guardians or others into whose care the resident will be released once discharged from the facility.

1. For children/youth/young adults enrolled in the PFC, the plan of care shall be developed in conjunction with the PFC entity coordinating the beneficiary's care and shall be included in the ISP.

(d) The individual plan of care shall prescribe an integrated program of therapies, activities, and experiences designed to meet the treatment objectives.

(e) The individual plan of care shall include post-discharge plans, and coordination of inpatient services with partial care discharge plans and related community services to ensure the continuity of care with the resident's family school and community upon discharge.

1. For PFC enrolled children/youth/young adults, post discharge plans shall include and be coordinated with the ISP prepared by the child-family team (CFT) as facilitated and

coordinated by the child/youth/ young adult's CMO care coordinator.

(f) The PRTF interdisciplinary team shall review the resident's individual plan of care, at a minimum, every 30 days to:

1. Determine that the services being provided are or were required on an inpatient basis; and
2. Recommend changes in the plan as indicated by the resident's overall adjustment and progress in treatment. (See 42 C.F.R. 441.155.)

(g) The child/youth/young adult, his or her parent or guardian and representatives from the CMO shall be included in the facility's review of the plan of care.

10:75-2.5 Individual treatment teams

(a) Each resident's individual treatment plan shall be developed by a treatment team comprised of physicians and other personnel responsible for rendering services to the resident in the PRTF. See 42 C.F.R. 441.156. The team shall:

1. Assess the long and short term therapeutic needs, developmental priorities, and the personal strengths and liabilities of the resident;
2. Assess the potential resources of the resident's family;
3. Set treatment objectives; and
4. Prescribe therapeutic modalities to achieve the objectives of the plan of care.

(b) The treatment team shall include, at a minimum, either:

1. A board-certified or board-eligible psychiatrist;
2. A clinical psychologist who has a doctoral degree and a physician licensed to practice medicine or osteopathy; or
3. A physician licensed to practice medicine or osteopathy with specialized training and experience in the diagnosis and treatment of mental diseases, and a psychologist who has a master's degree in clinical psychology or who has been certified by the State or by the State psychological association (see N.J.S.A. 45:14B-1 et seq.); and one of the following:

i. A psychiatric social worker;

ii. A registered nurse with specialized training or one year's experience in treating mentally ill individuals; or

iii. An occupational therapist who is licensed and who has specialized training or one year of experience in treating mentally ill individuals.

(c) For a child/youth/young adult who is enrolled in the PFC, the treatment team shall also include a minimum of one representative from the child-family team (CFT).

10:75-2.6 Utilization Review (UR)

In accordance with 42 C.F.R. 456.22, all Medicaid/NJ FamilyCare services shall have procedures that provide for review of each resident's need for the services. For the Utilization Review (UR), each PRTF shall perform on-going evaluations of the necessity and appropriateness of PRTF services for each resident. The UR shall include a review of the appropriateness of the admission, individual plan of care, length of stay and discharge plan.

10:75-2.7 Temporary absence from the facility

(a) A provider may seek reimbursement for a resident's temporary absence from the facility due to a hospital or therapeutic leave for periods of up to 14 continuous days per episode. If the beneficiary is present in the facility for any part of the day, beginning and ending at midnight, the HCPCS procedure codes for a day of service shall be used for that day. (See N.J.A.C. 10:75- 5.2.)

1. "Therapeutic leave" means a temporary absence (more than 24 consecutive hours) from the facility. Reasons for therapeutic leave include, but are not limited to, visits with parents, foster parents or guardians, attendance at a residential camp, or residence in a temporary shelter.

2. "Hospital leave" means a temporary absence (more than 24 consecutive hours) from the facility due to inpatient treatment in a hospital. Treatment in a psychiatric unit of a hospital may also be considered hospital leave.

(b) When anticipated, temporary absences shall first be approved by the resident's treatment team and included in the treatment plan. In the case of an unanticipated absence, the circumstances of the absence shall be documented in the resident's chart within 24 hours of the resident's departure from the facility.

END OF SUBCHAPTER 2

SUBCHAPTER 3. EMERGENCY SAFETY INTERVENTIONS

10:75-3.1 Scope

This subchapter describes the requirements of 42 C.F.R. 483.50 through 483.376, related to the use of restraints and seclusion, as these requirements are applied to PRTF providers of Medicaid services.

10:75-3.2 Definitions

The following words and terms, as used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise:

"Drug used as a restraint" means any drug that is administered to manage a resident's behavior in a way that reduces the safety risk to the resident or others; has the temporary effect of restricting the resident's freedom of movement; and is not a standard treatment for the resident's medical or psychiatric condition.

"Emergency safety intervention" means the use of any form of restraint or seclusion as an immediate response to stabilize an emergency safety situation.

"Emergency safety situation" means unanticipated resident behavior that places either the resident or other beneficiaries and/or staff, at serious threat of violence or injury if no intervention occurs and calls for an emergency safety intervention because non-restraining interventions have not worked to deescalate the situation.

"Mechanical restraint" means any device attached or adjacent to the resident's body, that he or she cannot easily remove, that restricts freedom of movement or normal access to his or her body.

"Personal restraint" means the application of physical force without the use of any device, for the purpose of restricting the free movement of a resident's body. Personal restraint does not include briefly holding a resident in order to calm or comfort the resident, or holding a resident's hand or arm to safely escort a resident from one area to another.

"Restraint" means a personal hold of any duration, a mechanical restraint, or a drug used as a restraint.

"Seclusion" means involuntary confinement of a resident alone in a room or an area from which the resident is physically prevented from leaving. A "time out" intervention is not considered seclusion.

"Time out" means the restriction of a resident for a period of time in a designated area from which the resident is not physically prevented from leaving, for the purpose of providing the resident an opportunity to regain self-control.

10:75-3.3 General principles

(a) Restraint and seclusion shall be considered emergency safety interventions and shall be used in emergency situations solely to minimize or avoid the likelihood of harm to the residents or staff of the PRTF.

(b) Restraint and seclusion shall never be ordered or used as a means of coercion, discipline, retaliation, or for the convenience of staff members.

(c) Choice of restraint and seclusion shall be limited to the least restrictive intervention that can be performed safely and is appropriate to the severity if the behavior, and the resident's age, developmental status, size, gender, physical, medical and psychiatric condition and personal history (including any history of physical or sexual abuse).

(d) The restraint or seclusion shall terminate once the emergency situation has ended, even if the order for restraint or seclusion has not expired.

(e) Restraint and seclusion shall never be ordered or used simultaneously.

10:75-3.4 Communication regarding the use of emergency safety interventions

(a) All residents shall be informed of all facility policies related to the use of restraint or seclusion upon admission to the facility. In the case of a resident who is under the age of 18, the resident's parent or legal guardian shall be informed of the policies.

(b) The policies shall be explained orally and provided in writing in a language that the resident and/or the resident's parent or legal guardian understands.

(c) The written policies shall include the contact information for the State's Protection and Advocacy agency.

NJ Protection and Advocacy
210 South Broad Street, 3rd floor
Trenton, NJ 08608

(d) The resident, or the resident's parent or legal guardian, shall sign an acknowledgement that this policy was provided to them and that they understand the policy. This written and signed acknowledgement shall be placed in the resident's file.

10:75-3.5 Staff training and certification

(a) All full and part-time clinical and direct care staff shall be trained in the following areas:

1. The use of non-physical and non-restraining intervention skills, such as de-escalation, mediation, conflict resolution, active listening, and verbal and observational methods to prevent emergency safety situations; and
2. Safe and appropriate restraint and seclusion techniques, including the ability to respond to signs of physical distress in beneficiaries who are being restrained or in seclusion, including adult and child cardiopulmonary resuscitation (CPR). Competency or certification in CPR shall

be demonstrated and documented annually.

(b) Staff training shall include training exercises in which staff demonstrates in practice the techniques they have learned for managing emergency safety situations.

1. All full and part-time clinical and direct care staff shall demonstrate their competencies in the safe use of restraint and seclusion before they are permitted to participate in an emergency safety intervention, and shall additionally demonstrate such competencies every six months thereafter.

(c) The facility shall document the completion of all training and competency demonstrations in the employee's personnel record, including the date of the training and the name(s) of the persons certifying the completion of the training.

(d) Administrators shall provide additional training as indicated to ensure staff proficiency.

(e) All training programs and materials shall be available for review by:

1. The Centers for Medicare & Medicaid Services (CMS);
2. The New Jersey Division of Medical Assistance and Health Services or its agents (for both in-State and out-of-State agencies); and
3. The State survey agency, which is the New Jersey Department of Health and Senior Services, for the New Jersey facilities.

(f) Any and all staff members who may not be directly involved in the use of restraints and seclusion techniques should be trained in the proper protocols and procedures to quickly notify a direct care or clinical staff member to defuse a situation or to secure additional help and assistance for staff who are directly involved in the use of an emergency situation.

10:75-3.6 Appropriate timelines for use of restraint of seclusion techniques

(a) Restraint and seclusion shall only be used in emergency situations. These techniques are intended to be used for a limited time period, and only to ensure the safety of the resident and other residents and staff in the immediate area.

Example: A resident in a PRTF facility has become agitated beyond the point of being calmed by non-restraining interventions. The individual is actively trying to physically harm either himself or other people in the area. In this situation, the use of restraint may be ordered to ensure that the agitated individual does not physically harm either himself or another resident or staff person in the area.

(b) As soon as the resident and the situation are stabilized, the use of the restraint or seclusion shall cease immediately.

(c) The following time limits for the use of either restraint or seclusion shall be the maximum time limits allowed:

1. Not to exceed a total of four hours for residents ages 18 through 21;
2. Not to exceed a total of two hours for residents ages nine through 17; and

3. Not to exceed a total of one hour for residents under the age of nine.

10:75-3.7 Mechanical restraint, drug restraint, or seclusion

(a) The resident's treatment team physician shall order the use of mechanical restraint, drug restraint or seclusion, as follows:

1. If someone other than the treatment team physician orders the mechanical or drug restraint or seclusion, the treatment team physician shall be contacted as soon as reasonably possible, but no later than the next regular business day, and shall be informed that the order was placed.

2. For in-State facilities, if the treatment team physician is unavailable, a physician, advance practice nurse, or physician's assistant shall order the use of a restraint or seclusion. Facilities may use on-call staff, per diem staff, consultants or other methods of pooling coverage in order to meet this requirement.

3. Out-of-State facilities providing services to New Jersey Medicaid/NJ FamilyCare beneficiaries shall follow the state Medicaid program requirements of the state in which they are located.

(b) An order for mechanical or drug restraint or seclusion shall not be written as a standing order or on an as-needed (PRN) basis. Each order shall be limited to a period of time which is no longer than necessary to resolve the emergency safety situation.

(c) The order placed shall be for the least restrictive intervention that is the most likely to be effective in resolving the situation, based on consultation with staff.

(d) The ordering practitioner shall provide written orders whenever possible, but may provide verbal orders over the phone under the following conditions:

1. For in-State facilities, the verbal order shall be received by an advance practice nurse, registered nurse, or physician's assistant. Out-of-state facilities shall follow the state Medicaid program requirements of the state in which they are located;

2. The order shall be received while the emergency safety intervention is being initiated by staff or immediately after the emergency safety situation ends.

3. The practitioner giving the order shall be available to the staff, at a minimum by telephone, for consultation throughout the entire period of the intervention; and

4. The practitioner shall, as soon as possible, document, sign and date the verbal order, and the circumstances requiring the order.

(e) The documentation of each order shall include the licensed practitioner's name and title, the date and time the order was obtained, and the emergency safety intervention ordered, including the length or time authorized for its use.

10:75-3.8 Personal restraint

(a) The resident's treatment team physician shall order the use of personal restraint, as follows:

1. If someone other than the treatment team physician orders the personal restraint, the

treatment team physician shall be contacted as soon as reasonably possible and shall be informed that the order was placed.

2. If the treatment team physician is unavailable, a licensed member of the child's treatment team or other member of the treatment team authorized by the facility to order a personal restraint, shall order the use of a personal restraint. In-State facilities may use on-call or per diem staff; however, the treatment team physician shall be notified as soon as reasonably possible, but no later than the next regular business day.

3. Out-of-State facilities providing services to New Jersey Medicaid/NJ FamilyCare beneficiaries shall follow the state Medicaid program requirements of the state in which they are located.

(b) An order for personal restraint shall not be written as a standing order or on an as-needed (PRN) basis. Each order shall be limited to a period of time which is no longer than necessary to resolve the emergency safety situation.

(c) The order placed shall be for the least restrictive intervention that is the most likely to be effective in resolving the situation, based on consultation with staff.

(d) The ordering practitioner shall provide written orders whenever possible, but may provide verbal orders over the phone under the following conditions:

1. For in-State facilities, a member of the treatment team who is not precluded from receiving such an order and who is permitted by the facility to receive the order, a registered nurse or other licensed staff as permitted by State law, shall receive the verbal order;

2. The order shall be received while the emergency safety intervention is being initiated by staff or immediately after the emergency safety situation ends;

3. The practitioner giving the order shall be available to the staff, at a minimum by telephone, for consultation throughout the entire period of the intervention; and

4. The practitioner shall, as soon as possible, document, sign and date the verbal order, and shall document the circumstances requiring the order.

(e) Each order shall include the licensed practitioner's name and title, the date and time the order was obtained, and the emergency safety intervention ordered, including the length of time authorized for the use of the intervention.

10:75-3.9 Resident monitoring

(a) Clinical staff who have been trained in the appropriate use of restraints shall be physically present in order to continually evaluate and monitor the physical and psychological well-being of the resident being restrained throughout the duration of the intervention.

(b) Clinical staff who have been trained in the appropriate use of seclusion shall be continually monitoring the resident who has been placed in seclusion. The staff persons shall be physically present in the room or immediately outside the seclusion room to ensure the safety of the resident. Video monitoring shall not meet this requirement.

(c) If the emergency safety intervention continues beyond the time limit specified in the order given by the physician/practitioner, staff who have been authorized to receive the order as indicated at N.J.A.C. 10:75-3.5 and 3.6 shall contact the physician/practitioner who initiated the order for further instructions.

(d) A physician, advance practice nurse, registered nurse, physician's assistant or other licensed practitioner trained in the use of emergency safety interventions, who are not precluded by regulation to conduct an evaluation, shall conduct a face-to-face evaluation of the physical and psychological well-being of the individual involved in the emergency safety intervention within one hour of the initiation of the intervention.

1. The one-hour assessment shall include, but shall not be limited to:
   i. The resident's physical and psychological status, including the resident's behavior;
   ii. The appropriateness of the intervention; and
   iii. Any complications resulting from the use of the intervention.
2. Facilities may need to use more than one staff person in order to assure that both parts of the evaluation are completed. For example, a registered nurse may conduct the physical evaluation, but a licensed clinical social worker may conduct the psychological evaluation, if deemed appropriate by the facility.

(e) Out-of-state facilities that provide services to NJ Medicaid/NJ FamilyCare beneficiaries shall follow their state Medicaid requirements regarding who is authorized to perform the evaluation required in (d) above.

10:75-3.10 Notification of the parent(s) or legal guardian(s)

(a) The facility shall notify the parent(s) or legal guardian(s) of the resident as soon as possible after the initiation of the intervention.

(b) Documentation shall be included in the resident's file, and shall include, but shall not be limited to:

1. The name of the individual notified;
2. The date and time of the notification; and
3. The printed name, signature and title of the staff member(s) providing the notification.

10:75-3.11 Evaluation after the emergency safety intervention

(a) Immediately after the drug or mechanical restraint or seclusion is over, for in-State facilities, a physician, an advance nurse practitioner, a registered nurse or a physician's assistant who is trained in the use of emergency safety interventions shall evaluate the physical and mental condition of the resident. Staff may use on-call staff to perform either or both parts of the evaluation as long as they assure the evaluation is completed timely. Out- of-State facilities shall follow their state Medicaid program requirements for who shall perform this evaluation.

(b) Immediately after the personal restraint is over, for in-State facilities, licensed staff who are not precluded from making an evaluation of the well- being of the child, and who are trained in

the use of emergency safety interventions, shall evaluate the well-being of the resident. Staff may use more than one staff member to perform both parts of the evaluation as long as they assure the evaluation is completed timely. Out-of-State facilities shall follow their state Medicaid program requirements for who shall perform this evaluation.

(c) For all emergency safety interventions, staff shall document the intervention no later than the end of the shift in which the emergency safety intervention ended. Documentation shall include, at a minimum:

1. The name of the physician/practitioner who gave the order;
2. The date and time that the order was given, including the name and title of who received the order;
3. The type of intervention order, including the length of time authorized for the use of the intervention;
4. The actual time of the initiation and termination of the intervention;
5. The actual time and results of all evaluations performed during or after the intervention;
6. The emergency safety situation that required the use of the intervention; and
7. The name, title and credentials of all staff involved in the intervention.

(d) If the practitioner ordering the intervention is not the resident's treatment team physician, the ordering practitioner, or the professional receiving the order, shall consult with the resident's treatment team physician as soon as possible to advise the physician of the intervention. Documentation of the date and time the treatment team physician was consulted shall be included in the resident's record.

(e) All entries into the record shall be legible and the person entering the information shall print and sign their name in ink, including their title and the date that the entry was made.

10:75-3.12 Medical treatment for injuries resulting from the use of emergency safety interventions

(a) Staff shall immediately obtain medical treatment from qualified medical personnel for treatment of any injury sustained by any individual as a result of an emergency safety intervention.

(b) The facility shall have affiliations or written transfer agreements in effect with the closest hospitals in the area that can provide needed treatment for the resident. If possible, the facility should use Medicaid/NJ FamilyCare- participating hospitals.

(c) The agreements or affiliations shall ensure that:

1. A resident will be admitted to the hospital when necessary for medical or acute psychiatric care;
2. Medical and other information needed for the care of the resident that is allowed to be exchanged in accordance with a State's medical privacy law will be exchanged between the two facilities;
3. Services are available 24 hours a day, seven days a week; and

4. All injuries to the resident and the staff that occurred as a result of the safety intervention shall be recorded in the resident's record.

(d) Injuries resulting from the use of restraint or seclusion shall be considered a serious occurrence and shall be reported to all required individuals and government agencies in accordance with the requirements of N.J.A.C. 10:75-1.6.

10:75-3.13 Debriefings

(a) As soon as reasonably possible, but no later than 24 hours after the incident, the staff members and beneficiaries involved in the incident shall have a face-to-face discussion. This discussion may include other staff members and/or the resident's legal guardians, as deemed appropriate by the facility. If the presence of a particular staff member would jeopardize the well-being of the resident, then that staff person may be excused from this discussion by administrative staff.

1. The discussion shall provide both the resident and staff an opportunity to discuss the circumstances resulting in the intervention, and strategies to be used by the staff, resident or others to prevent the future use of an intervention.

(b) Within 24 hours after the use of a restraint or seclusion, all staff involved in the use of restraint or seclusion, and appropriate facility administrative and supervisory clinical staff, shall conduct a debriefing which shall identify:

1. The factors that led to the use of the intervention;
2. Alternative interventions that could have been used to prevent the intervention;
3. The procedures, if any, that staff are to implement to prevent any reoccurrence of the use of restraint or seclusion; and
4. The outcome of the intervention, including any injuries that may have resulted from the use of the intervention.

(c) Staff shall document in the resident's record that the debriefings required in (a) and (b) above occurred, and shall include:

1. The names of the staff who were present;
2. The names of the staff who were excluded, and the reasons for the absence of those staff members;
3. The date and time of the debriefing;
4. The resident's attendance and level of participation in the debriefing; and
5. Any changes made to the resident's treatment plan as a result of the debriefing.

(d) If there is an injury to a resident or staff member as a result of the use of restraint or seclusion, the staff member(s) involved with the intervention shall meet with supervisory staff and evaluate the circumstances that resulted in the injury, in order to develop a plan to prevent future injuries.

END OF SUBCHAPTER 3

SUBCHAPTER 4. REIMBURSEMENT

10:75-4.1 Basis of reimbursement

(a) Reimbursement for PRTC services provided in JCAHO accredited facilities shall be on a per diem rate. These rates shall be based on reasonable negotiated contracted costs, as defined in the Department of Human Services' Contract Reimbursement Manual and the Contract Policy and Information Manual. Providers have access to these manuals as indicated at N.J.A.C. 10:3-3.3(e) 12.

1. PRTCs shall submit claims only for those procedure codes that correspond to the allowable services included in their Medicaid/NJ FamilyCare provider application approval letter. Claims for reimbursement shall be submitted on the CMS-1500 claim form to:

Unisys
PO Box 4808
Trenton, New Jersey 08650-4808

(b) The reimbursement rate shall include medically necessary PRTC services. These services shall include, but shall not be limited to:

1. Room and board costs;
2. Clothing that is required as part of a treatment regimen;
3. Temporary absence from the facility due to authorized therapeutic or hospital leave days (see N.J.A.C. 10:75-1.6); and
4. Transportation necessary for treatment purposes.

(c) Reimbursement for PRTC services provided in JCAHO accredited facilities that are operated by the State shall be based on reasonable costs reported on quarterly cost reports prepared on a cost allocation plan for the Department of Human Services, in accordance with 45 C.F.R. 95.501 through 95.519. The costs for each quarter will be divided by the total number of days that the residents received services, resulting in a reimbursement rate based on actual costs to be used for monthly billings.

(d) Medicaid/NJ FamilyCare in-State providers of non-State operated PRTFs who meet the requirements in (a) through (c) above and that achieve a level of service above 85 percent will be eligible to receive a one-time incentive payment equal to one-half the difference between the actual level of service percentage and 85 percent. Any level of services above 90.5 percent shall not qualify for this incentive payment.

1. These incentive payments will take the form of an adjustment to the amount paid in excess of the provider's reimbursable contract ceiling and will be determined at contract closeout.

2. The base used for determining the incentives will be the actual audited contract closeout data, limited to include service activity beginning on or after January 1, 2001 through the last date of the contract term ending on or prior to December 31, 2001. Future cost reports will not be adjusted to reflect this payment.

(e) Reimbursement for all PRTC services shall not exceed Federal upper payment limits as defined in 42 C.F.R. 447.325.

10:75-4.2 Billing procedures

(a) Beginning on the date of admission, and for each subsequent whole day that a resident is under the care of the PRTF, the provider shall seek reimbursement using the appropriate HCPCS procedure code as defined in N.J.A.C. 10:75-5.2.

(b) Providers shall request reimbursement for services provided on the date that the resident adult is admitted to the facility, but shall not request reimbursement for services provided on the day that the resident is discharged from the facility. Discharged means that the resident has been discharged from the facility and is not reasonably expected to return to the facility.

(c) Providers may bill for consecutive dates of service on the same claim line, but shall not span dates from more than one month on any given claim lime. Therapeutic and hospital leave days shall be indicated on separate lines and reimbursement shall be requested using the appropriate HCPCS code, as defined in N.J.A.C. 10:75-5.2.

END OF SUBCHAPTER 4

SUBCHAPTER 5. HEALTHCARE COMMON PROCEDURE CODING SYSTEM (HCPCS)

10:75-5.1 Introduction

(a) The New Jersey Medicaid/NJ FamilyCare program utilizes the Centers for Medicare and Medicaid Services' Healthcare Common Procedure Coding System (HCPCS). HCPCS follows the American Medical Association's Physicians' Current Procedural Terminology (CPT) architecture, employing a five-position code and as many as two 2-position modifiers. Unlike the CPT numeric design, the CMS assigned codes and modifiers contain alphabetic characters. HCPCS was developed as a three-level coding system.

1. Level I Codes (Narratives found in CPT): These codes are adapted from the CPT for utilization primarily by Physicians, Certified Nurse Practitioners and Independent Laboratories. CPT is a listing of descriptive terms and numeric identifying codes and modifiers for reporting medical services and procedures performed by physicians.

i. Copyright restrictions make it impossible to print excerpts from the CPT procedure narratives for Level I codes. Thus, in order to determine those narratives, it is necessary to refer to the CPT, which is incorporated herein by reference, as amended and supplemented. The CPT is available in medical bookstores or may be obtained by contacting the American Medical Association at 515 North State Street, Chicago, IL 60610, telephone: 312-464-5000, website: http://www.ama-assn.org.

2. Level II Codes: These codes are assigned for physicians and non-physician services that are not found in the CPT.

3. Level III Codes: These codes are assigned by the Division to be used for those services not identified by CPT codes or HCFA-assigned codes. Level III codes identify services unique to the New Jersey Medicaid/NJ FamilyCare or PFC programs.

(b) Regarding specific elements of HCPCS procedure codes which require the attention of the provider, the lists of HCPCS code numbers are arranged in tabular form with specific hospital or program information for a code identified under columns with titles such as: "IND," "HCPCS CODE," "MOD," "DESCRIPTION," and "MAXIMUM FEE ALLOWANCE." The program information identified under each column is summarized below:

Column Title	Description
IND	(Indicator) Lists alphabetic symbols used to refer provider to hospital or program information concerning the New Jersey Medicaid/NJ FamilyCare fee-for-service program's qualifications and requirements when a procedure or service code is used. Explanation of indicators and qualifiers used in this column are identified below.
HCPCS Code	Lists the HCPCS procedure code numbers.
Mod	Lists alphabetic and numeric symbols. Services and procedures may be modified under certain circumstances. When applicable, the modifying circumstance should be identified by the addition of alphabetic and/or numeric characters at the end of the code.
Description	Lists the code narrative. (Narratives for Level I codes are found in CPT.)

Maximum Fee Allowance	Lists the New Jersey Medicaid/NJ FamilyCare fee-for-service program's maximum reimbursement schedule for the defined services.

(c) Regarding alphabetic and numeric symbols under "IND" and "MOD," these symbols when listed under the "IND" and "MOD" columns are elements of the HCPCS coding system used as qualifiers or indicators (as in the "IND" column) and as modifiers (as in the "MOD" column). They assist the physician/practitioner in determining the appropriate procedure codes to be used, the area to be covered, the minimum requirements needed and any additional parameters required for reimbursement purposes.

1. These symbols and/or letters shall not be ignored because, in certain instances, requirements are created in addition to the narrative that accompanies the CPT/HCPCS procedure code as written in CPT. The provider will then be liable for the additional requirements and not just the CPT/HCPCS procedure code narrative. These requirements shall be fulfilled in order to receive reimbursement.
2. If there is no identifying symbol listed, the CPT/HCPCS code narrative prevails.

10:75-5.2 PRTF procedure codes

IND	HCPCS CODE	MOD	DESCRIPTION	MAXIMUM FEE ALLOWANCE
	Y9947		Mental health rehabilitation services provided in JCAHO accredited RTCs licensed by the Division of Mental Health Services.	Contract pricing
	Y9948		Mental health rehabilitation services provided in JCAHO accredited PRTFs licensed by the Division of Youth and Family Services.	Contract pricing
	Y9949		Therapeutic Leave – JCAHO accredited PRTFs licensed by the Division of Mental Health Services or enrolled by the Division of Medical Assistance and Health Services.	Contract pricing
	Y9950		Hospital Leave – JCAHO accredited PRTFs licensed by the Division of Mental Health Services or under contract with the Division of or enrolled by the Division of Medical Assistance and Health Services.	Contract pricing

Y9951	Therapeutic Leave for beneficiaries residing in JCAHO accredited RTCs licensed by DYFS	Contract pricing
Y9952	Hospital Leave for beneficiaries residing in JCAHO accredited RTCs licensed by DYFS	Contract pricing

END OF SUBCHAPTER 5